Retiree Benefit Plan Enrollment

FOR NEW RETIREES ONLY

MONTGOMERY COUNTY PUBLIC SCHOOLS Maryland

CLEAR FORM

Employee and Retiree Service Center (ERSC)
MONTGOMERY COUNTY PUBLIC SCHOOLS
45 West Gude Drive, Suite 1200 • Rockville, Maryland 20850

INSTRUCTIONS

All new retirees must make a selection in each category. Complete, sign electronically or manually on both sides of this form, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or email a PDF of the signed form to ERSC@mcpsmd.org. This form must be signed at the bottom of pages 1 and 2. Please do not mail copies to ERSC once you have faxed or emailed the enrollment form. A confirmation of your requested change(s) will be sent to you. Unsigned forms will be returned to you and become your responsibility to resubmit to ERSC by the appropriate deadline.

SECTION I: RETIREE INFORMATION

SECTION I: RETIREE INFORMATION—Please print. If your address has changed, please submit MCPS Form 445-1B, *Change in Personal Information for MCPS Retirees and Former Employees* with your benefit enrollment form. Benefit enrollment confirmations are sent to the address on file.

Name _____ Employee ID#_____ SSN # ___ ___ ___ ___
last 4 digits

Address: Street _____ City_____ State ____ Zip_____

Home Phone _____-_____-_____ Email _____ **Retiree Date of Birth** _____/_____/_____

Retirement Date _____/_____/_____ (new and existing retirees) **Spouse Date of Birth** _____/_____/_____

SECTION II: RETIREE ENROLLMENT INFORMATION

- ❑ Continuation of benefits in retirement—effective with retirement date.
  Please complete MCPS Form 455-4, *Request for Refund of MCPS Prepaid Benefits*.
- ❑ Continuation of benefits in retirement—effective October 1 (for 10-month employees retiring in July, August, or September)
- ❑ Transfer to active spouse MCPS plan, ID#_____ (must include MCPS Form 455-20, *Employee Benefit Plan Enrollment)*
- ❑ I cancel/decline all benefit plan enrollment effective _____/_____/_____ *(Date of cancellation must adhere to deadline rules in RBS)*—skip to **SECTION VI, LIFE INSURANCE OPTION**

SECTION III: RETIREE LEVEL OF HEALTH COVERAGE

- ❑ Individual
- ❑ Two-Party
- ❑ Family

SECTION IV: RETIREE BENEFIT PLAN ENROLLMENT INFORMATION

SECTION IV: RETIREE BENEFIT PLAN ENROLLMENT INFORMATION—You must make a selection in each category A-D. Please consult the Retiree Benefit Summary for benefit plan enrollment qualifications. **Medicare-eligible retirees (and their eligible dependents) must enroll in Medicare Parts A and B to continue coverage with MCPS.** If you enroll in a **private Medicare Part D plan,** all MCPS prescription coverage will be cancelled.

CATEGORY A (Medical Plans)—

PLEASE SELECT ONE (1) OF THE FOLLOWING OPTIONS

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

- ❑ Cigna Open Access Plus In-Network (OAPIN)
- ❑ Kaiser Permanente HMO

OPEN POINT-OF-SERVICE (POS) PLANS[1]

- ❑ Cigna Open Access Plus (OAP)

INDEMNITY/MEDICARE SUPPLEMENTAL PLANS

- ❑ Cigna Indemnity/Medicare Supplemental Plan
- ❑ I ***decline*** medical coverage

[1] *When a retiree or dependent becomes Medicare-eligible, this health plan does not coordinate with Medicare. At the time of Medicare Part B enrollment, a plan change will be required. When no plan change is submitted, coverage will default to the Indemnity/Medicare Supplemental Plan.*

CATEGORY B (Prescription Drug Plans)—Please select one

- ❑ Caremark (available to all non-Medicare-eligible retirees **except** Kaiser HMO members) ❑ Option A ❑ Option B
- ❑ SilverScript/Caremark Part D plan for Medicare-eligible participants (available to ages 65 + only) ❑ Option A ❑ Option B
- ❑ Kaiser (**only** available to Kaiser HMO members)
- ❑ I ***decline*** prescription drug coverage

CATEGORY C (Dental Plans)—Please select one

- ❑ CareFirst Preferred Provider Organization (PPO)
- ❑ Aetna Dental Maintenance Organization (DMO)
  (Benefit plan participant must reside in a DMO service area.)
- ❑ I ***decline*** dental coverage

CATEGORY D (Vision Plan)—Please select one

- ❑ Davis Vision (provided through CareFirst)
- ❑ I ***decline*** vision coverage

SIGNATURE REQUIRED ON PAGES 1 AND 2

I understand that my electronic submission of this form, and my electronic signature, are intended to be, constitute, and are equivalent to my personal signature.

Signature _____ Date _____/_____/_____

SECTION V: COVERED PARTICIPANTS—To enroll or drop dependent(s).

First Name	Last Name	MI	Social Security #	Date of Birth	Sex	Enroll/ Drop
Spouse						❑/❑
Child						❑/❑
Child						❑/❑

FOR ADDITIONAL COVERED DEPENDENTS, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

SECTION VI: BASIC TERM LIFE INSURANCE

❑ Continue at retirement (Complete section VII and list all beneficiaries)

❑ I **cancel/decline** Basic Term Life Insurance (You may not reenroll once life insurance is cancelled.)

SECTION VII: LIFE INSURANCE BENEFICIARY DESIGNATION

- Benefits shall be divided equally among primary beneficiaries (or contingent beneficiaries), unless otherwise stated.
- The contingent beneficiary(ies) shall be entitled to life insurance benefits in the event there is no surviving primary beneficiary.
- If designating a Trust as a beneficiary, please provide a copy of the title, trustee, address, and signature pages of the Trust.

Please check **Primary** or **Contingent** for each designated beneficiary. If neither box is checked, the named beneficiary will be deemed as a **primary** beneficiary.

❑ No change

❑ **Primary**

Name _____

Address _____

Share _____ % Relationship _____

❑ **Primary** ❑ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____

❑ **Primary** ❑ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____

❑ **Primary** ❑ **Contingent**

Name _____

Address _____

Share _____ % Relationship _____

FOR ADDITIONAL BENEFICIARIES, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

SIGNATURE REQUIRED ON PAGES 1 AND 2

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Signature _____ Date ____/____/____